U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 September 2003

Case No. : 2002-BLA-5155

In the Matter of:

JAMES L. PROFFITT,
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Dick Adams, Esq.
For the Claimant

Martin E. Hall, Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by James L. Proffitt for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

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[1] The Director, OWCP, was not represented at the hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

A formal hearing in this case was held in Madisonville, Kentucky on November 6, 2002. Each of the parties was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon my observation of the appearance and the demeanor of the witness who testified at the hearing, and upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. Statement of the Case

The Claimant, James L. Proffitt, filed his second claim for black lung benefits on June 11, 2001 (DX 3).[2] A Notice of Claim was issued on June 21, 2001, identifying Island Creek Coal Company as the putative responsible operator (DX 15). On July 15, 2001, August 24, 2001, and October 31, 2001, the Employer filed its Response to Notice of Claim (DX 16, 18, 21). The District Director, OWCP, made an initial determination of entitlement (DX 27). The Employer requested a formal hearing and the claim was referred to the office of Administrative Law Judges on May 15, 2002 (DX 32).

A hearing was held in Madisonville, Kentucky on November 6, 2002, before the undersigned Administrative Law Judge. At the hearing, the undersigned reserved ruling on the Claimant's objections to Employer's Exhibits 1-11 and the post-hearing admission of deposition transcripts from Drs. Repsher, Powell, and Branscomb (Tr. 9-10, 30). The parties were granted leave to brief these issues. After briefs were filed and carefully

[2] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits and "Tr." refers to the transcript of the November 6, 2002 hearing.

considered, the undersigned, by Order on June 13, 2003, sustained the Claimant's objections to the admission of Employer's Exhibits 1-11. The record was held open for 30 days until July 13, 2003 to allow the Employer to identify which evidence it wished to have considered in light of the evidentiary limitations contained in § 725.414, and the record was held open until August 13, 2003 for submission of briefs (*See* June 13, 2003 Order). The Employer subsequently submitted Exhibits 1-5, in accordance with the evidentiary limitations of § 725.414. Employer's Exhibits 1-5 have been admitted and considered in this Decision.

The Claimant had previously filed a claim for federal black lung benefits on July 6, 1982, which was ultimately denied by the Department of Labor (DX 1).

II. Issues[3]

The controverted issues as listed on Form CM-1025 are as follows:

1. Whether the claim was timely filed;

2. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

3. Whether the Miner's pneumoconiosis arose out of coal mine employment (Tr. 11-12);

4. Whether the Miner's disability is due to pneumoconiosis (Tr. 11-12);

5. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c)-(d), (Tr. 11-12); and,

6. The remaining issues set forth in paragraph 18, as well as the issues as to constitutionality of the Act and its regulations, are reserved for appeal purposes.

[3] At the hearing, controversion was withdrawn to the issues of miner, post-1969 employment, cumulative employment, responsible operator and length of employment. The parties stipulated to 34 years of coal mine employment (Tr. 11).

III. Findings Of Fact And Conclusions Of Law

The Claimant, James L. Proffitt, was born on July 22, 1925, and is 77 years old (DX 3; Tr. 23). The Claimant completed the ninth grade (DX 3). The Claimant has one dependent for purposes of augmentation of benefits; namely, his wife, Opal Elise (Teague) Proffitt, whom he married on May 18, 1946 (DX 3).

The Claimant started smoking in 1944, smoking approximately one pack of cigarettes per day until 1983 (DX 10; Tr. 27).

Coal Mine Employment

On his application, the Claimant stated that he worked in coal mine employment for 34-36 years (DX 3; Tr. 14). At the hearing, the parties stipulated to 34 years of coal mine employment (Tr. 11).

This stipulation is supported by the Claimant's submitted Employment History form, Social Security earnings record, State Worker's Compensation Award letter, and the Miner's allegations. I find that the Claimant has established 34 years of coal mine employment.

The Claimant testified that over the relevant period, he ran a "duck bill," worked on a belt, worked at a loading point, ran a motor, and worked as a shelter car operator (Tr. 15). The Claimant routinely lifted 40-60 pounds up to 60 times per day (DX 5). The Claimant quit coal mine employment in 1982 (Tr. 18). The Claimant filed a state black lung claim, which was approved (Tr. 18).

The Claimant's last employment was in the Commonwealth of Kentucky. As such, the law of the Sixth Circuit is controlling.

Responsible Operator

Island Creek Coal Company has withdrawn its challenge to the issue of responsible operator, and I find that Island Creek Coal Company is properly named as responsible operator pursuant to §§ 725.494, 725.495 (Tr. 11).

Timeliness

The Claimant filed a claim for federal black lung benefits on July 6, 1982, which was ultimately denied by the Department of Labor on April 2, 1986 (DX 1). The reason cited for denial

was that the evidence in the claim did not show that the Claimant was totally disabled by pneumoconiosis (DX 1). The Claimant's current subsequent claim was filed on June 11, 2001 (DX 3). The Employer contests that the subsequent claim was timely filed (DX 32).

Claims for benefits under the Act are accorded a statutory presumption of timeliness. § 718.308(c). A claim is timely filed if it was filed before the expiration of three years after a "medical determination of total disability due to pneumoconiosis" is communicated to the miner. § 718.308(a); 30 U.S.C. § 932(f). The Sixth Circuit has issued three relevant decisions on the application of § 718.308.

In *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), the Sixth Circuit held that the time period in which a miner must file for benefits, under § 718.308(a), starts after each denial of a previous claim, provided that the miner works in the coal mines for a substantial period of time after the denial and a new medical opinion of total disability due to pneumoconiosis is communicated. *Sharondale*, 42 F.3d at 996. Ross, the claimant, was initially denied benefits under the Act in 1981. He began working again as a coal miner before quitting in 1983. He filed a duplicate claim in 1985. Accordingly, the Sixth Circuit found that Ross' claim was timely filed. In *Sharondale*, the Sixth Circuit explicitly declined to hold that the statute of limitations applied only to the filing of initial claims. *Id*. The Sixth Circuit found that due to logic and the progressive nature of pneumoconiosis, it would make no sense to allow serial applications for benefits and then limit the ability to file serial applications to three years. *Id*.

Five years later, the Sixth Circuit addressed the application of § 718.308 in *Tennessee Consolidated Coal Co. v. Kirk,* 264 F.3d 602 (6th Cir. 2001). Beginning in 1979, Kirk filed three claims for benefits, all of which were denied. *Kirk*, 264 F.3d at 604. Kirk filed his fourth claim in 1992 and was awarded benefits. *Id.* The Sixth Circuit found that Kirk's 1992 claim was timely filed, stating:

> The three-year statute of limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial

> of benefits. There is thus a distinction between premature claims that are unsupported by medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period.

Id. at 608.

The Sixth Circuit stated that Kirk's three prior denials did not trigger the statute of limitations because they were premature filings, noting that previous medical opinions did not conclusively opine that Kirk was totally disabled due to pneumoconiosis. Then the Court referenced its unpublished decision in *Clark v. Karst-Robbins Coal Co.*, No. 93-4173, 1994 WL 709288 (6th Cir. 1994), where it rejected a successful state workers' compensation claim that relied upon a finding that the claimant became permanently and totally disabled as the result of the occupational disease of pneumoconiosis as a "medical determination."

The Sixth Circuit addressed the timeliness issue most recently and most definitively in *Peabody Coal Co. v. Director, OWCP [Dukes]*, 48 Fed. Appx. 140, 2002 WL 31205502 (6th Cir. October 2, 2002) (unpub.). Between 1987 and 1988, Dukes received several opinions from physicians that he was suffering from pneumoconiosis. He filed a claim for benefits under the Act in 1988, which was denied by a Department of Labor claims examiner. Dukes did not appeal, and he never returned to coal mining. In 1995, he filed a duplicate claim for benefits and he was awarded benefits. The Sixth Circuit engaged in a thorough and complete analysis of the three-year statute of limitations, wherein they characterized *Kirk* as holding that no "medical determination" exists absent a valid medical opinion, notwithstanding prior knowledge or existence of the disease. *Dukes*, 48 Fed. Appx. at 144. The Sixth Circuit adopted the reasoning of the Tenth Circuit, holding that a "final finding ... that the claimant is not totally disabled due to pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations. *Id*., citing to *Wyoming Fuel Co. v. Director, OWCP [Brandolino]*, 90 F.3d 1502, 1507 (10th Cir. 1996).

Claimant's original claim was denied on April 2, 1986, thereby repudiating any communication of medical opinions to the Claimant that he was totally disabled due to pneumoconiosis prior to April 2, 1986 for the purpose of determining the timeliness of the Claimant's subsequent filing.

There is no medical evidence in the record for the period between April 2, 1986 and the filing of the subsequent claim on June 11, 2001. The earliest medical opinion after the 1986 denial is the July 2001 examination by Dr. Simpao.

As the medical opinions in the old claim were repudiated for purposes of timely filing, and as there is no medical opinion of total disability due to pneumoconiosis prior to the filing of the subsequent claim, I find that the June 11, 2001 subsequent claim was timely filed.

IV. Medical Evidence

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standard
1.	10/18/74	DX 1	Coffman	Little fibrosis	Not listed
2.	9/16/82	DX 1	Stokes Board cert.[4]	3/2, p, all six zones	Good
3.	9/16/82	DX 1	Cole B reader[5] Board cert.	2/1,q, all six zones	Fair
4.	9/16/82	DX 1	Morgan B reader	0/1, t,t	Poor
5.	9/27/82	DX 1	Morgan	0/1 q,t	Good
6.	9/27/82	DX 1	Marshall B reader Board cert.	2/2, q,q all six zones	good

[4] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

[5] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

7.	9/27/82	DX 1	Brandon B reader Board cert.	2/2 q	Fair
8.	9/27/82	DX 1	O'Neill	2/2 p/q	Good
		Comments:	Bilateral reticulonodular infiltrate in mid and lower lung zones.		
9.	2/7/83	DX 1	Powell	1/1 q,q	Good
10.	3/18/83	DX 1	Gallo	Pneumo., 2p	Good
		Comments:	Bilateral reticulonodulation.		
11.	1/26/84	DX 1	Taylor	Pneumo., 1 p	Unlisted
		Comments:	Much volume loss seen in left lung base. "I am not sure of its significance." Lungs otherwise clear.		
12.	12/31/91	EX 1	Trover	Normal	Unlisted
		Comments:	Heart and pulmonary vasculature normal; lungs clear, no abnormality.		
13.	7/19/01	DX 10	Simpao	1/2 p,q	Good
14.	7/19/01	DX 11	Sargent B reader Board cert.	Quality only	Fair Lungs overexposed mottling/ artifacts
15.	7/19/01	DX 22	Wiot B reader Board cert.	Normal	Poor
		Comments:	Very difficult film to evaluate as it is highly contrasty and shows extensive mottle. Evidence of previous sternotomy, hiatus hernia.		
16.	7/19/01	EX 2	Spitz B reader	Normal	Good
		Comments:	Previous sternotomy; lungs clear; no evidence of cwp.		
17.	10/03/01	DX 12	Powell B reader	1/1 q,p	Good/Unreadable
		Comments:	Not full inspiratory effort/overexposed.		

18.	10/03/01	EX 2	Wiot B reader Board cert.	Normal	Poor
		Comments:	Previous sternotomy; chest unremarkable; no evidence of cwp		
19.	10/03/01	EX 2	Spitz B reader	Normal	Fair Underexposed
		Comments:	Previous sternotomy; lungs clear; no evidence of cwp.		
20.	01/25/02	CX 1	Whitehead B reader Board cert.	1/2 p,q	Good
21.	1/25/02	EX 2	Wiot B reader Board cert.	Normal	Good
		Comments:	Previous sternotomy; no evidence of cwp.		
22.	10/03/02	EX3	Repsher B reader Board cert.	Normal/ CABG	Fair/Dark

Pulmonary Function Studies

	Date	Exh.	Doctor	Age/Hgt[6]	FEV_1	MVV	FVC	Qualifying
1.	9/16/82	DX 1	Simpao	57/67"	.61	.65	.86	No/invalid[7]
	Comments:	Tracings included; poor effort, poor comp., good coop. Uninterpretable.						
2.	8/27/85	DX 1	Taylor	60/69"	1.61	7	1.87	No/invalid
	Comments:	Tracings included; sub-optimum effort.[8]						
3.	7/19/01	DX 10	Simpao	75/66"	1.0	8	1.66	Yes
	Comments:	Tracings included; effort, coop. and comp. good.						

[6] I must resolve the height discrepancy on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that the Miner's actual height is 67 inches.

[7] Little or no weight may be accorded to a ventilatory study where the miner exhibits "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984).

[8] *See* note 7. I find "sub-optimum effort" to be poor effort, and therefore find this test invalid.

4.	10/03/01	DX 12	Powell	76/66.5"	.70	--	1.12	No/invalid
			Post Bronchodilator		.77	--	1.16	

Comments: Sub-maximal effort, results not reportable.

5.	1/25/02	CX 1	Houser	76/67"	1.83	49.53	2.60	No
			Post-Bronchodilator		1.81	51.40	2.46	

Comments: Tracings included; coop. and comp. not listed.

6.	10/03/02	EX 3	Repsher	77/67"	1.18	22	1.94	No/invalid
			Post Bronchodilator		1.51	--	2.07	

Comments: Tracings included: effort poor.

Arterial Blood Gas Studies

	Date	Exhibit	Doctor	pCO_2	pO_2
1.	9/16/82	DX 1	Simpao	35.5	78.9
2.	9/27/82	DX 1	Anderson	34	68
3.	2/7/83	DX 1	Powell	37	64.2
4.	3/18/83	DX 1	Gallo	31	70
5.	1/26/84	DX 1	Taylor	27	73
6.	7/19/01	DX 10	Simpao	40	81.2
7.	10/03/02	EX 3	Repsher	38.2	81

Narrative Medical Evidence

1. Dr. Frank H. Taylor, Board certified in Internal Medicine and Pulmonary Medicine, examined the Claimant on January 26, 1984 (DX 1). Based on symptomatology, employment history (37 years underground coal mine employment), individual and family histories (malignant melanoma of right arm, ulcer), physical examination, chest x-ray (category 2p pneumoconiosis), arterial blood gas study (normal), and an EKG (incomplete right bundle branch block), Dr. Taylor diagnosed category 2p pneumoconiosis, left diaphragmatic paralysis, and history of malignant melanoma. He noted the normal arterial blood gas readings, and stated he had no other objective evidence to establish the degree of the Claimant's pulmonary impairment. He further noted that "patient refuses to take pulmonary function studies. Previous pulmonary function studies have revealed poor effort." With the data presented, Dr. Taylor opined that there

was sufficient objective data presented to justify the diagnosis of pneumoconiosis, related to coal mine work, which would prevent the Claimant from doing his regular job in the mines. Dr. Taylor did not note a smoking history in his evaluation.

2. Dr. Thomas A. Gallo examined the patient on March 18, 1983 (DX 1). Based on symptomatology (wheezing, coughing, "no wind"), employment history (35-36 years of coal mine work), smoking history (one pack a day since 1944, quit in 1982), individual history, physical examination, chest x-ray, pulmonary function test (no usable info due to lack of effort), arterial blood gas study, and an EKG, Dr. Gallo diagnosed coal workers' pneumoconiosis, category 2, and chronic bronchitis.

3. a. Dr. Robert W. Powell, Board certified in Internal Medicine, subspecialty in Pulmonary Disease and a B reader, examined the Claimant on February 7, 1983 (DX 1). Based on symptomatology (shortness of breath, can only walk one block without stopping), employment history (36 years coal mine work), smoking history (½-1½ pack per day), individual history, physical examination (lungs show fine inspiratory crackles at both posterior bases), chest x-ray (1/1 q,q), pulmonary function test (consistent effort not achieved, no reportable results), arterial blood gas study, and an EKG, Dr. Powell diagnosed category 1/1, q,q coal workers' pneumoconiosis, probable early congestive heart failure, hypertension on this one exam, and acquired deafness.

b. Dr. Powell examined the patient again on October 3, 2001 (DX 12). Based on symptomatology (shortness of breath, wheeze and cough), employment history (34 years coal mine employment), smoking history (from age 19 to 1983, 1½ packs per day), individual history, physical examination (lungs have crackles at both bases, heart normal), chest x-ray (1/1, q,p), pulmonary function test (no reportable results), arterial blood gas study (normal), and an EKG (normal), Dr. Powell diagnosed pneumoconiosis. Dr. Powell stated that one of the x-rays reviewed was overexposed with reasonably good inspiratory effort while the second x-ray was not a full inspiratory film. Dr. Powell noted that the x-rays showed pulmonary vascular congestion and nodularity of sufficient profusion to be consistent with pneumoconiosis. Dr. Powell opined that the condition arose in whole from coal mine employment. Dr. Powell further stated that he could not conclude whether the Claimant suffers from a respiratory impairment in that pulmonary function tests were invalid. Dr. Powell noted that the arterial blood gas study was normal. Dr. Powell opined that the Claimant is

totally and permanently disabled from doing coal mine work, but that the Claimant's disability was not caused in whole or in part by coal workers' pneumoconiosis.

c. In his October 3, 2002 deposition, Dr. Powell restated the findings of his 2001 report (EX 4). In review of other medical records provided to Dr. Powell, Dr. Powell opined that the January 2002 pulmonary function study produced valid results showing a mild obstructive ventilatory defect (p. 19). Dr. Powell testified that a history of cigarette use was the likely cause of the obstructive ventilatory defect (p. 20). Dr. Powell testified that the Claimant does not have a totally disabling respiratory impairment, but rather is totally disabled due to age, heart disease, and inability to walk well (p. 20). This total disability is not caused by, related to, or significantly aggravated by the Claimant's simple coal workers' pneumoconiosis or his exposure to coal dust (p. 20).

4. Dr. William H. Anderson examined the Claimant on September 27, 1982 (DX 1). Based on symptomatology (short of breath, can only go up two flights of stairs), employment history (34 years coal mine employment), smoking history (started at age 18, quit twice, smoke 1/2 pack a day), individual history (kidney operation), physical examination (difficulty hearing), chest x-ray, pulmonary function test (no reportable results), arterial blood gas study, and an EKG (normal), Dr. Anderson diagnosed category 2 pneumoconiosis and symptoms of arteriosclerotic heart disease, noting that the Claimant was uncooperative in the pulmonary function study.

5. Dr. Valentino S. Simpao, Board certified in Internal Medicine, subspecialty in Pulmonary Disease, examined the Claimant on July 19, 2001 (DX 10). Based on symptomatology, employment history (34 years of coal mine employment), smoking history (1944-1983, one pack per day), individual and family histories, physical examination, chest x-ray (1/2), pulmonary function test (severe degree both restrictive and obstructive airway disease), arterial blood gas study (normal), and an EKG, Dr. Simpao diagnosed coal workers' pneumoconiosis, category 1/2, with an etiology of multiple years of coal dust exposure. Dr. Simpao opined that the impairment was severe and that the Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. Dr. Simpao stated that the combined objective readings of the chest x-ray, pulmonary function test, symptomatology, and physical findings supported a diagnosis of pneumoconiosis.

6. Dr. William Houser examined the Claimant on January 25, 2002 (CX 1). Based on symptomatology (can walk about 1/2 block before developing dyspnea, minimal cough, some wheezing), employment history (34 years of coal mine employment), smoking history (total of about 20 years, quit in 1983, one pack per day), individual history (rosacea, bronchoscopy, lung biopsy, open heart surgery), physical examination (lungs show late inspiratory rales at both bases), chest x-ray (1/2 p,q), and pulmonary function test (nonqualifying), Dr. Houser diagnosed: (1) coal workers' pneumoconiosis, category 1/2; (2) chronic obstructive pulmonary disease (moderately severe); (3) history of pneumothorax; (4) arteriosclerotic heart disease with history of myocardial infarction, status post coronary bypass; and, (5) additional problems relating to past medical history.

Dr. Houser attributed the etiology of the coal workers' pneumoconiosis to 34 years of coal mine employment and the etiology of the chronic obstructive pulmonary disease to cigarette smoking and exposure to coal and rock dust. He based these diagnoses on the results of the x-rays, physical examination, and pulmonary function results. Dr. Houser noted inspiratory rales at both bases which did not clear on expiration; some rhonchi and wheezing. Dr. Houser stated that the Claimant is totally and permanently disabled, and that pneumoconiosis was a significant contributing factor to the respiratory impairment and resulting disability.

7. a. Dr. Lawrence Repsher, Board certified in Internal Medicine, subspecialty in Pulmonary Disease and Critical Care, and a B reader, examined the Claimant on October 3, 2002 (EX 3). Based upon symptomatology (progressive dyspnea on exertion, occasional dry cough), employment history (35 years coal mine employment), smoking history (one pack per day for 20 years over a 40-year period), individual and family histories, physical examination (breath sounds mildly reduced, crackles 2/3 up the left chest, no rhonchi or wheezes), chest x-ray (0/0), pulmonary function study (unreportable due to poor effort), arterial blood gas study (normal), EKG (left anterior hemiblock/old myocardial infarction), CT scan (normal, with minimal granulomatous disease at left base, mild nonspecific parenchymal scarring, previous CABG), and a review of previous records, Dr. Repsher diagnosed: (1) no evidence of coal workers' pneumoconiosis; (2) probable normal pulmonary function; (3) coronary artery disease; (4) osteoarthritis; (5) peptic ulcer disease and GERD;

(6) hypertension; (7) decreased hearing; and, (8) malignant melanoma.

Dr Repsher explains his diagnosis of no pneumoconiosis, stating that there is no x-ray evidence of cwp, there is no pulmonary function test evidence of cwp, arterial blood gas readings are normal, and the evidence shows coronary artery disease strongly suggestive of congestive heart failure. Dr. Repsher opines that the objective data shows that the Claimant "is not now and never has suffered from coal workers' pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as an underground coal miner."

b. In his deposition on October 26, 2002, Dr. Repsher restated his earlier findings (EX 5). Dr. Repsher testified that in his October 2002 x-ray interpretation, the apparent p and q sized opacities seen were, in his opinion, due to looking at the blood vessels rather than actual small opacities of pneumoconiosis (p. 13). Dr. Repsher reviewed the July 19, 2001, the October 3, 2001 and the January 25, 2002 pulmonary function tests and opined that the results were invalid and, further, to rely upon them would be below the standard of care (p. 15). Dr. Repsher states that the Claimant is disabled, but that the disability is due to age (76 years old), and because of his underlying pulmonary artery disease status post CABG (p. 18).

V. Discussion And Applicable Law

The Claimant, James L. Proffitt, filed a claim for black lung benefits on June 11, 2001 (DX 3). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[9]

Material Change in Conditions

The amended regulations contain a threshold standard that the Claimant must meet before his claim may be reviewed *de novo*.

> A subsequent claim shall be processed and adjudicated under the provisions of subparts E

[9] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

> and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement ... has changed since the date upon which the order denying the prior claim became final. ... For example, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in Part 718 of this sub-chapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously."

Section 728.309(c)-(d).

The Claimant's 1982 claim was denied because the Claimant did not establish that he was totally disabled due to pneumoconiosis arising out of coal mine employment pursuant to § 718.204 (DX 1). The Claimant did establish the existence of pneumoconiosis arising out of coal mine employment (DX 1). To obtain the right to a *de novo* review of his subsequent claim, therefore, the Claimant must first establish that he is now totally disabled due to pneumoconiosis or his claim must be denied without further review pursuant to § 728.309(c)-(d).

Specifically, the Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *See, e.g. Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally

disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

The record contains six pulmonary function studies. Four of the six tests were invalidated due to poor effort. In addition to the invalid results listed, the Claimant refused a pulmonary test with Dr. Taylor (DX 1), and Drs. Anderson and Gallo were unable to obtain reportable readings on their examinations due to poor effort (DX 1). The July 19, 2001 study gives marginally qualifying readings, while the January 25, 2002 study produced nonqualifying results. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). The Claimant has a 20-year history of poor effort. Given four reportable tests with invalid results, given the newest valid test exhibits nonqualifying results, and noting Dr. Repsher's opinion that the July 19, 2001 test, while marginally qualifying, is also invalid, I find the pulmonary function tests do not support a finding of total disability due to pneumoconiosis.

The record contains seven arterial blood gas studies. All arterial blood gas testing results are nonqualifying except for the January 26, 1984 test. More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). As six of the seven tests are nonqualifying, including the two most recent tests (which were conducted 17-18 years after the lone qualifying reading), I find that the arterial blood gas studies do not support a finding of total disability due to pneumoconiosis.

There is no evidence presented, nor do the parties contend that the Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

The remaining method for the Claimant to prove disability is through a reasoned medical opinion. There are five medical narratives in the record discussing the Claimant's impairment level. Drs. Gallo and Anderson, while examining physicians, did not give an opinion as to the disability level of the Claimant, and I will not consider their opinions in regards to disability.

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying

documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.,* 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F. 2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Taylor, Board certified in Internal Medicine, based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, and arterial blood gas study. Based on the information gathered, Dr. Taylor opined that there was sufficient objective data presented to justify that the Claimant would be unable to perform his regular job in the mines due to pneumoconiosis arising out of coal mine employment.

Dr. Taylor's opinion is not well reasoned. Dr. Taylor states that the arterial blood gas readings are normal. He further notes that the Claimant refused to take a pulmonary study test and, therefore, he had no objective evidence to diagnose the degree, if any, of the Claimant's pulmonary impairment. Dr. Taylor does not discuss how smoking relates to his diagnosis. Given the other objective normal readings, Dr. Taylor's opinion appears to be based on his own x-ray interpretation (2p pneumoconiosis), the Claimant's symptoms (cough, wheezing), and physical exam results (few rales on the right side of lungs). Dr. Taylor lists no special training in interpreting x-rays.

Although a report cannot be discredited simply because a physician did not consider all medical data of record, it is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, *i.e.*, x-ray, blood gas, and ventilatory studies. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986). Given normal blood gas readings, the lack of a valid pulmonary analysis, the failure to account for the Claimant's smoking history, and Dr. Taylor's lack of listed x-ray credentials, Dr. Taylor's statement that there is sufficient objective data to make a diagnosis of total disability appears ill conceived. Most of his findings are based on subjective data given by the

Claimant and observed during examination. I find Dr. Taylor's opinion not well reasoned and afford it less weight in the establishment of total disability due to pneumoconiosis.

Dr. Powell, Board certified in Internal Medicine and Pulmonary Disease, based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and arterial blood gas study. Based on the information gathered, Dr. Powell stated that the Claimant is totally disabled, but that the Claimant's disability was not caused in whole or in part by coal workers' pneumoconiosis.

Dr. Powell's report is well reasoned. Dr. Powell reviews not only the data, but the quality of the data, noting x-ray quality problems, invalid pulmonary function tests, and normal arterial blood gas levels. Dr. Powell found the January 2002 pulmonary function study valid (but non-qualifying), showing a mild obstructive ventilatory defect, likely caused by cigarette smoking. He found sufficient x-ray evidence of pulmonary vascular congestion and nodularity to form a diagnosis of pneumoconiosis.

In a collective review of all objective data, including the Claimant's physical examination, Dr. Powell opined that the Claimant is totally disabled, but attributes that disability to age, heart disease, and the inability to walk well, and not to diagnosed pneumoconiosis. While I note that Dr. Repsher disagrees with Dr. Powell's finding that the January 2002 pulmonary study is valid, I, nevertheless, find the report of Dr. Powell to be based on the objective data, well documented, well explained, and thus, well reasoned. I afford this opinion substantial weight in support of a finding of no total disability due to pneumoconiosis.

Dr. Simpao, Board certified in Internal Medicine and Pulmonary Disease, based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and arterial blood gas study. Based on the information gathered, Dr. Simpao opined that the x-ray evidence, symptomatology, and pulmonary function study show that the Claimant's impairment is severe and that the Claimant does not have the respiratory capacity to perform the work of a coal miner. He further opined that the total disability is due to coal workers' pneumoconiosis.

Dr. Simpao's opinion is not well reasoned. Dr. Simpao utilizes multiple sources of objective data (x-ray, pulmonary study, symptomatology, physical findings) to support and explain his diagnosis. The analysis presented is logical and documented. I take note, however, that Dr. Simpao lists no special training in interpreting x-rays, and further note that the July 19, 2001 x-ray relied on by Dr. Simpao was read as negative by Dr. Wiot who is a Board-certified Radiologist and B reader, and as negative by Dr. Spitz, a B reader. The pulmonary study relied upon by Dr. Simpao was found to be invalid by Dr. Repsher (who is also Board certified in Internal Medicine and Pulmonary Disease). Dr. Simpao did not discount the normal arterial blood gas readings, nor did he explain how the Claimant's extensive smoking history figured into this diagnosis. In total, I find that the opinion of Dr. Simpao is not well reasoned, and is based, in part, on questionable objective data. As such, I afford his opinion less weight in support of a finding of total disability due to pneumoconiosis.

Dr. Houser based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, and pulmonary function study. Based on the information gathered, Dr. Houser opined that the Claimant is totally and permanently disabled, and based that diagnosis on an etiology of pneumoconiosis and cigarette smoking.

Dr. Houser's opinion is well reasoned. As Dr. Houser lists no special training in the interpretation of x-rays, he relies on the interpretation of Dr. Whitehead, a Board-certified Radiologist and a listed B reader. (I note that Dr. Wiot, also Board certified and a B reader, found this same film to be negative).

Dr. Houser relies on the January 2002 pulmonary study which Dr. Repsher found to be invalid and whose readings are nonqualifying. Dr. Houser finds the test valid, however, and notes that post-bronchodilator readings are not significantly changed from pre-bronchodilator readings, suggesting permanent, moderate obstructive pulmonary impairment.

Dr. Houser's opinion reflects the Claimant's smoking history and its concurrent impact on the Claimant's condition. I note that Dr. Houser's exam does not include an arterial blood gas study. Dr. Houser notes rales, wheezes, and rhonchi in the lungs. As Dr. Houser relies on objective data and incorporates the Claimant's smoking history into his evaluation, I find the

opinion of Dr. Houser well reasoned supporting a finding of total disability.

Dr. Repsher, Board certified in Internal Medicine, Pulmonary Disease, Critical Care, and a B reader, based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, CT scan, and arterial blood gas study. Based on the information gathered, Dr. Repsher opined that the Claimant does not even suffer from pneumoconiosis, and further stated that the Claimant's disability is related in whole to age and underlying pulmonary artery disease.

Dr. Repsher's opinion is well reasoned. Dr. Repsher notes the invalid results of prior pulmonary studies, normal arterial blood gas readings, a normal CT scan, and an EKG suggesting coronary artery disease. With no objective data to suggest pulmonary impairment, Dr. Repsher opines that all objective data points to coronary artery disease strongly suggestive of congestive heart failure. Dr. Repsher explains how the other physicians could have misread x-rays that appeared to show opacities, why he found the other pulmonary function tests to be invalid, and concludes that with no objective data to support pulmonary or respiratory disease, the Claimant is totally disabled, not by pneumoconiosis, but rather by his advanced age (76 years old) and his heart-related conditions. I find that Dr. Repsher's diagnosis is supported by objective data and well documented. I find the opinion of Dr. Repsher to be well reasoned and I afford it substantial weight in the finding of no disability due to pneumoconiosis.

I find the well-reasoned, but contrary opinion of Dr. Houser to be outweighed by the opinions of Drs. Powell and Repsher. The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Here, Drs. Powell and Repsher are both Board certified in Internal Medicine and Pulmonary Disease, while Dr. Houser lists no special training. In addition, greater weight may be accorded that opinion which is supported by more extensive documentation over the opinion which is supported by limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-6 (1988). In this case, Drs. Repsher and Powell conducted EKG's and arterial blood gas studies while Dr. Houser did not. Dr. Repsher added a CT scan to his diagnosis, while Dr. Houser did not. Given the superior credentials and the use of more

extensive objective data by Drs. Powell and Repsher, I give their opinions greater weight over the opinion of Dr. Houser.

As a result of invalid, questionable, or nonqualifying pulmonary testing results, normal blood gas test results, and the well-reasoned opinions of Drs. Powell and Repsher that the Claimant suffers from no pulmonary or respiratory disability, but rather suffers from age and heart-related conditions, I find that the Claimant has failed to establish a total disability due to pneumoconiosis arising out of coal mine work under § 718.204(b)(2). The opinions of Drs. Taylor and Simpao, while contrary, are not well reasoned.

As a finding of total disability due to pneumoconiosis is the threshold requirement to allow a *de novo* review of the Miner's subsequent claim, I find that the Claimant's claim must be denied without further review.

VI. Entitlement

James L. Proffitt, the Claimant, has not established entitlement to benefits under the Act because he has not established the material change of conditions necessary to entitle him to a *de novo* review pursuant to § 718.309(c)-(d).

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of James L. Proffitt for benefits under the Act is hereby DENIED.

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Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.